

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A1S (4)
15M 9/SS

4383

CERTIFICATE OF DEATH

64330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2 Box 186</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Fred</u> First <u>Dyer</u> Middle <u>D</u> Last <u>YER</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1890</u> <u>4/7/1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Dyer</u>				14. MOTHER'S MAIDEN NAME <u>Alice Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Willie Dyer, Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 1960</u> to <u>Apr. 14, 1960</u> , that I last saw the deceased alive on <u>Apr. 14, 1960</u> , and that death occurred at <u>3:26 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. L. Small</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton, Md.</u> DATE SIGNED <u>4-15-60</u>			
PHYSICIAN'S NAME (Type) <u>H. L. SMALL MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Rt. 2, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Dahill</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8323

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF PHYSICIAN _____</p>	
<p>10. SIGNATURE OF REGISTRAR _____</p>		<p>11. SIGNATURE OF WITNESS _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH
 BALTIMORE

27

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4379

CERTIFICATE OF DEATH

04331

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTIE MORTHA HARRIS</u>				4. DATE OF DEATH Month <u>APR</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13, 1910</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Pollard</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond Harris</u> Address <u>Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Uterus and Ovary</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>55</u> , to <u>April 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>60</u> , and that death occurred at <u>1a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D.				Dent on, Md			
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Hoover for Denton</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knott</u>	

174X

DEPARTMENT OF HEALTH - BALTIMORE 1933		CERTIFICATE OF DEATH	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE OF REGISTRATION [Faint text]		PLACE OF REGISTRATION [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4381
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64332

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Collins Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle B. Last Harris		4. DATE OF DEATH Month 4 Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-1883
9. AGE (In years lost birthday) yrs. 76		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 54 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. S. Pennell		14. MOTHER'S MAIDEN NAME Mary Emma Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address George W. Harris Ridgely, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE. DUE TO (left Hemiplegia) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart DUE TO Disease. (c) Disease.		INTERVAL BETWEEN ONSET AND DEATH 6 days 5415	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 16 1960 to April 16 1960 , that (I) (we) last saw the deceased alive on April 16 1960 , and that death occurred at 530 PM from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott		22b. DATE SIGNED 4/21/60	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott M.D.		22d. ADDRESS Ridgely, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-60	
23c. NAME OF CEMETERY OR CREMATORY Chester		23d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouclair		25a. REC'D BY REGISTRAR APR 25 '60	
ADDRESS Greensboro, Md.		25b. REGISTRAR'S SIGNATURE C. E. H. H. H.	

1938

CENTRAL DEATH

1938

Married

Married

Married

Married

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Married

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be removed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4384

CERTIFICATE OF DEATH

Reg. Dist. No.

64333

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b X Rural Ridgely	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Emmett Lynch		4. DATE OF DEATH Month Apr. Day 22, Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail carrier		10b. KIND OF BUSINESS OR INDUSTRY Postoffice	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Lynch		14. MOTHER'S MAIDEN NAME Elizabeth Bechtel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW2		16. SOCIAL SECURITY NO. 216-38-7724	
17. INFORMANT Mrs. William E. Lynch, Ridgely, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 to 1953 , that I last saw the deceased alive on 19 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Kurt Lederer		ADDRESS (Street, city or town, state) Queen Anne, Md. DATE SIGNED 4/25	
PHYSICIAN'S NAME (Type) Kurt Lederer M.D.		Queen Anne, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or county) (State) Denton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Denton		ADDRESS Denton, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

PLACE OF BIRTH [Blank]		SEX [Blank]	
DATE OF BIRTH [Blank]		AGE [Blank]	
NAME OF DECEASED [Blank]		NAME OF FATHER [Blank]	
NAME OF MOTHER [Blank]		NAME OF SPOUSE [Blank]	
PLACE OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
DATE OF DEATH [Blank]		TIME OF DEATH [Blank]	
PLACE OF INTERMENT [Blank]		NAME OF INTERMENT SOCIETY [Blank]	
NAME OF PHYSICIAN [Blank]		NAME OF CLERGYMAN [Blank]	
NAME OF FUNERAL HOME [Blank]		NAME OF UNDERTAKER [Blank]	
NAME OF BURIAL PLACE [Blank]		NAME OF CEMETERY [Blank]	
NAME OF CITY [Blank]		NAME OF COUNTY [Blank]	
NAME OF STATE [Blank]		NAME OF COUNTRY [Blank]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4385

CERTIFICATE OF DEATH

Reg. Dist. No.

64334

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gary Wayne Murphy		4. DATE OF DEATH Month Day Year Apr. 9 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1960
9. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Murphy		14. MOTHER'S MAIDEN NAME Elizabeth Poist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert Murphy, Hillsboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inflammation of the colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Megacolon DUE TO (c) pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 1960 , to April 9, 1960 , that I last saw the deceased alive on April 9, 1960 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kurt Lederer		ADDRESS (Street, city or town, state) Queen Anne Rd	
DATE SIGNED 4/11/60			
PHYSICIAN'S NAME (Type) Kurt Lederer M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF April 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Hillsboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Burton		ADDRESS Baltimore, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

2080214XV4

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

CERTIFICATE OF DEATH

64335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>LeRoy</u> Middle <u>Nuttle</u> Last				4. DATE OF DEATH <u>April</u> Month <u>24</u> Day <u>1960</u> Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1875</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William B. Nuttle</u>				14. MOTHER'S MAIDEN NAME <u>Addie F. Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-46-3411</u>		17. INFORMANT <u>Glenn C. Nuttle</u> Address <u>Denton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis General</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Semiprimer</u> (c) <u>Shock due to fall</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs -</u> <u>2 yrs -</u> <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>11</u> a. m. <u>4:22</u> 19 <u>60</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Denton</u> (County) <u>Caroline</u> (State) <u>Md</u>							
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>51</u> , to <u>April 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>60</u> , and that death occurred at <u>7:32 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Denton Md</u>				DATE SIGNED <u>4-25-60</u>			
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DAWSON O. George</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kneass</u> ADDRESS <u>Denton Md</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Kneass</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	
DATE <u>APR 28 '60</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4386

CERTIFICATE OF DEATH

Reg. Dist. No.

64337

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL DENTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HOUSTON</u> Middle <u>THAWLEY</u> Last <u>SR.</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1896</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HOUSTON THAWLEY SR.</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Parrie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>John Houston Thawley</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinoma of the Cervical Spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>59</u> , to <u>April 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>60</u> , and that death occurred at <u>12:20</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Stokesifer</u> M.D.				ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u>		DATE SIGNED <u>Apr. 11, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Stokesifer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virginia Moore</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

183X